



**Commonwealth of Massachusetts  
Group Insurance Commission**

P.O. Box 8747 • BOSTON, MA 02114-8747  
(617) 727-2310 [www.mass.gov/gic](http://www.mass.gov/gic)

**Insurance Enrollment and Change Form  
(FORM - 1)**

01 <input type="checkbox"/>		Insured's GIC-ID (usually Soc. Sec. #)  — — —	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth / / /	Dept. ID # or Agency/Division # /
Name - Last		First		MI	
Address		<input type="checkbox"/> This is a new address	City		State Zip Code
Date Entered Service / /	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #:	Home Phone ( )		Work Phone ( )
02 <input type="checkbox"/>		<b>LIFE, HEALTH AND LTD COVERAGE</b>			<b>Effective Date:</b> / 01 /
New Enrollment: <input type="checkbox"/>	Change: <input type="checkbox"/>				<b>Cancel Coverage</b>
<input type="checkbox"/> <b>Basic Life Only</b> <input type="checkbox"/> <b>Long Term Disability (LTD)</b> <input type="checkbox"/> <b>Basic Life and Health</b> (Select one of the Health Plans below)		Annual Salary: \$ _____			<input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Health Insurance <input type="checkbox"/> Optional Life Insurance
<b>Health Plan</b> <input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (PPO) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO) <input type="checkbox"/> Health New England (HMO)		<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (PPO) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)			<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare/Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type)
<b>Optional Life</b> Please Check One: <input type="checkbox"/> <b>Automatic Increase</b> Indicate Multiple Factor (1-8): Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form. <input type="checkbox"/> <b>Non Automatic Increase</b> <b>Amount \$:</b> No more than \$1000 less than annual salary rounded down to the nearest \$1,000		<input type="checkbox"/> <b>Automatic Increase – Family Status Change</b> Indicate Multiple Factor (1 – 4) <input type="checkbox"/> <b>Non Automatic Increase – Family Status Change</b> <b>Amount \$:</b> No more than \$1000 less than annual salary rounded down to the nearest \$1,000 <i>Marriage, divorce, birth/adoption, death of spouse. The GIC must receive documentation of family status change within 31 days of the event.</i>			<b>Please Check One:</b> <input type="checkbox"/> <b>Smoker</b> <input type="checkbox"/> <b>Non-Smoker</b> Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates
03 <input type="checkbox"/> Name Change		Previous Name		New Name	
<b>LEAVE OF ABSENCE</b>					<b>FOR GIC USE ONLY:</b> <input type="checkbox"/> <b>Effective Date:</b> / 01 /
					Leave Pay Status: <input type="checkbox"/> Part <input type="checkbox"/> Full
04 <input type="checkbox"/> Leave Is: <input type="checkbox"/> With Pay <input type="checkbox"/> Without Pay		Leave Type (You MUST Check one of the following):			
		<input type="checkbox"/> Educational * <input type="checkbox"/> Personal Illness * <input type="checkbox"/> Industrial accident	<input type="checkbox"/> * Maternity <input type="checkbox"/> Sabbatical <input type="checkbox"/> Suspension	<input type="checkbox"/> Military Caregiver (26 weeks) <input type="checkbox"/> FMLA Military Exigency (12 weeks) <input type="checkbox"/> Military	<input type="checkbox"/> FMLA (12 weeks) <input type="checkbox"/> Family (for dep < age 3) <input type="checkbox"/> Other
* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.					
Duration of Leave:		Start Date / /	End Date / /	Last Day on Payroll / /	
05 <input type="checkbox"/> Return to Payroll Deduction:		First Day Back on Payroll / /		<b>FOR GIC USE ONLY:</b> <input type="checkbox"/> <b>Effective Date:</b> / 01 /	
<b>INSURED CHANGES</b>					
06 <input type="checkbox"/> Retirement		Date Retired / /		<input type="checkbox"/> ORP (Higher Ed Only) Fund Name: _____	
07 <input type="checkbox"/> Transfer to another Agency		Name of Agency Transferred to		Effective Date / /	
08 <input type="checkbox"/> Transfer from another Agency		Previous Agency		Effective Date / /	
09 <input type="checkbox"/> Termination Coverage (if elected)		Termination Reason		Termination Date / /	
		<input type="checkbox"/> 39-Week Layoff Coverage	<input type="checkbox"/> Deferred Retiree	<input type="checkbox"/> COBRA (must complete COBRA application)	<input type="checkbox"/> Conversion (contact carrier for application)
<b>SIGNATURE REQUIRED</b>	<b>Deduction Authorization:</b> I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. <b>Long Term Disability Insurance (LTD):</b> I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability. <b>Health Insurance:</b> I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan. <b>Optional Life Insurance:</b> I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change. <b>At Retirement:</b> I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage. <b>Survivors:</b> I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage. <b>Termination:</b> I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.				
	<input type="checkbox"/> If you are applying for Health Insurance, be sure to file a Form IDF to list family members.				
X _____		Signature of Applicant		X _____	
Entered _____		Date _____		Signature of Authorized Official	
Verified _____				Date _____	
<b>FOR GIC USE ONLY:</b>				Political Subdivision _____	